MENTAL HEALTH SYSTEMS

Elizabeth POTTER

INFORMED CONSENT FOR PSYCHOTHERAPY

As I have previously attested, I agree that I have received a copy of the therapist's Notice of Privacy Practices, Practice Information and Policies and Social Media Policy, and that I have read, understand and agree to the items contained in these documents. Proceeding with clear knowledge and forethought about these items, as well as both the benefits and risks of psychotherapy, I consent to participate in, or allow my child to participate in, the evaluation and treatment provided by Elizabeth Potter, LIMHP, LMHP, LADC.

I understand that my copayment, balance, or full fee is due at the beginning of each session, and that I may pay with cash, a personal check, or a credit card swiped in session, or with a charge to my on-file credit card after my session has ended. I understand that I must provide at least a 24-hour notice of intent to cancel a scheduled appointment, and that if I fail to do so (absent an emergency situation), a late cancelation fee of $100 will be applied. I also understand that a no show/no call event will result in a charge of my full session fee. For late cancelations or no shows of an initial intake appointment, a $100 late cancel/no show fee will be applied.

I understand that Elizabeth A. Potter, P.C. will keep my credit card information on file (in a PCI-compliant format) in the event it is necessary to use it to cover an outstanding balance on my account, and give my permission for these charges to be processed. I understand that every effort will be made to contact me regarding any outstanding balance before using my credit card information to cover it.

CONSENT FOR TELEHEALTH CONSULTATION

1. **I understand that my health care provider wishes me to engage in a telehealth consultation.**
2. **My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.**
3. **I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.**
4. **I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.**
5. **I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.**

Elizabeth A. Potter, P.C. Therapy Services 10831 Old Mill Suite 100 A, Omaha, NE 68154 at 402-317-5276

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CONSENT TO USE THE TELEHEALTH BY EITHER OPTUM (UHC INSURANCE), Spruce Video OR DOXY.ME

DOXY.ME is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. **Telehealth by DOXY.ME, Spruce Video and Optum Virtual Visit is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.**
2. **Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither DOXY.ME nor the Virtual Visit provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.**
3. **The Telehealth by DOXY.ME and Virtual Visit (UHC-Optum) facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.**
4. **I do not assume that my provider has access to any or all of the technical information in the Telehealth by DOXY.ME Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the DOXY.ME or Optum Virtual Visit program.**
5. **To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.**

By signing this form, I certify:

- **That I have read or had this form read and/or had this form explained to me.**
- **That I fully understand its contents including the risks and benefits of the procedure(s).**
- **That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.**

BY SIGNING BELOW, BOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ITEMS CONTAINED IN THIS CONSENT DOCUMENT.

_____

Client printed name (if minor) Client signature (if minor) Date

_____

Patient printed name (Legal Guardian) Patient signature (Legal Guardian) Date

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